FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011239

Facility Name: MARGARET MANOR INC.

Address: 1211 N. ORLEANS (Number) CHICAGO (City) 60610 (Zip Code)

County: COOK

Telephone Number: (312) 943-4300 **Fax #** (312) 943-4304

IDPA ID Number: 362554934001

Date of Initial License for Current Owners: 00/00/69

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) JEFFREY K. SINGER, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	135	Intermediate (ICF)	135	49,275	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	39,695	517	652	40,864	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,695	517	652	40,864	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.93%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 07/01/1969

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	92,445	19,453	38,967	150,865		150,865		150,865			1
2	Food Purchase		287,683		287,683	(28,496)	259,187	(36)	259,151			2
3	Housekeeping	58,076	53,735	95,947	207,758		207,758		207,758			3
4	Laundry	12,156	7,167		19,323		19,323		19,323			4
5	Heat and Other Utilities			78,023	78,023		78,023	1,267	79,290			5
6	Maintenance	21,826		133,515	155,341		155,341	(30,485)	124,856			6
7	Other (specify):*											7
8	**TOTAL General Services**	184,503	368,038	346,452	898,993	(28,496)	870,497	(29,254)	841,243			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	255,987	14,504	265,258	535,749		535,749		535,749			10
10a	Therapy			3,671	3,671		3,671		3,671			10a
11	Activities	66,685	4,444	4,566	75,695		75,695		75,695			11
12	Social Services	74,704		43,696	118,400		118,400		118,400			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	397,376	18,948	317,191	733,515		733,515		733,515			16
	C. General Administration											
17	Administrative	223,500		454,500	678,000		678,000	(318,389)	359,611			17
18	Directors Fees											18
19	Professional Services			34,116	34,116	(12,934)	21,182	5,302	26,484			19
20	Dues, Fees, Subscriptions & Promotions			19,156	19,156		19,156	(8,213)	10,943			20
21	Clerical & General Office Expenses	22,810	8,313	85,466	116,589		116,589	99,285	215,874			21
22	Employee Benefits & Payroll Taxes			88,302	88,302	28,496	116,798		116,798			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,154	1,154		1,154	(118)	1,036			24
25	Other Admin. Staff Transportation							2,283	2,283			25
26	Insurance-Prop.Liab.Malpractice			77,675	77,675		77,675	2,963	80,638			26
27	Other (specify):*							34,625	34,625			27
28	**TOTAL General Administration**	246,310	8,313	760,369	1,014,992	15,562	1,030,554	(182,262)	848,292			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	828,189	395,299	1,424,012	2,647,500	(12,934)	2,634,566	(211,516)	2,423,050			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MARGARET MANOR INC. #0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			44,960	44,960		44,960	10,867	55,827			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,274	2,274		2,274	14,216	16,490			32
33	Real Estate Taxes					12,934	12,934	80,018	92,952			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)				34
35	Rent-Equipment & Vehicles			7,210	7,210		7,210		7,210			35
36	Other (specify):*											36
37	**TOTAL Ownership**			354,444	354,444	12,934	367,378	(194,899)	172,479			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			10,825	10,825		10,825	(4,070)	6,755			41
42	Provider Participation Fee			73,913	73,913		73,913		73,913			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			84,738	84,738		84,738	(4,070)	80,668			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	828,189	395,299	1,863,194	3,086,682		3,086,682	(410,486)	2,676,196			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,190	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(36)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(10,437)	20		19
20	Contributions	(185)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,839)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,930)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(48,626)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (66,864)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(343,622)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (343,622)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (410,486)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

MARGARET MANOR INC.

ID# 0011239

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	PPA - SEMINAR	(200)	24	2
3	MISC INCOME	(285)	21	3
4	CAPITALIZED REPAIRS AND MAINTENANCE	(35,908)	06	4
5	VENDING INCOME	(4,070)	41	5
6	BLDG CO - PROFESSIONAL FEES	(5,120)	19	6
7	BLDG CO - TAXES	(3,043)	21	7
8				8
9				9
10				10
11				11
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(36)											(36)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,267									1,267	5
6	Maintenance	(35,908)		5,423									(30,485)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(35,944)		6,690									(29,254)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(452,500)	91,611	42,500							(318,389)	17
18	Directors Fees													18
19	Professional Services	(5,120)	5,120	5,302									5,302	19
20	Fees, Subscriptions & Promotions	(13,461)	120	5,128									(8,213)	20
21	Clerical & General Office Expenses	(14,258)	3,043	83,025		27,475							99,285	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(200)		82									(118)	24
25	Other Admin. Staff Transportation			2,283									2,283	25
26	Insurance-Prop.Liab.Malpractice			2,963									2,963	26
27	Other (specify):*			13,938	7,430	13,257							34,625	27
28	**TOTAL General Administration**	(33,039)	8,283	(339,779)	99,041	83,232							(182,262)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(68,983)	8,283	(333,089)	99,041	83,232							(211,516)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	6,190		4,677									10,867	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			14,216									14,216	32
33	Real Estate Taxes		77,751	2,267									80,018	33
34	Rent-Facility & Grounds		(300,000)										(300,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	6,190	(222,249)	21,160									(194,899)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(4,070)											(4,070)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(4,070)											(4,070)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(66,864)	(213,966)	(311,929)	99,041	83,232							(410,486)	45

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PETER O'BRIEN	60.00%	SEE ATTACHED		SEE ATTACHED		
DANIEL O'BRIEN	20.00%					
MARY O'BRIEN	20.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT INCOME	$ 300,000	BUILDING PARTNERSHIP		$	$ (300,000)	1
2	V	33	REAL ESTATE TAXES		BUILDING PARTNERSHIP		77,751	77,751	2
3	V	20	LICENSES AND FEES		BUILDING PARTNERSHIP		120	120	3
4	V	19	PROFESSIONAL FEES		BUILDING PARTNERSHIP		5,120	5,120	4
5	V	21	INCOME TAXES		BUILDING PARTNERSHIP		3,043	3,043	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 300,000			$ 86,034	$ * (213,966)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 1,267	$ 1,267	15
16	V	6	REPAIRS AND MAINT.				5,423	5,423	16
17	V	19	PROFESSIONAL FEES				5,302	5,302	17
18	V	20	DUES AND SUBSCRIPTIONS				5,128	5,128	18
19	V	21	CLERICAL AND GENERAL				83,025	83,025	19
20	V	24	SEMINARS				82	82	20
21	V	25	AUTO EXPENSE				2,283	2,283	21
22	V	26	PROPERTY INSURANCE				2,963	2,963	22
23	V	27	GEN. ADMIN. - EMP. BEN.				13,938	13,938	23
24	V	30	DEPRECIATION				4,677	4,677	24
25	V	32	INTEREST				14,216	14,216	25
26	V	33	REAL ESTATE TAXES				2,267	2,267	26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	452,500				(452,500)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 452,500			$ 140,571	$ * (311,929)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	$	MADO MGMT. LP	100.00%	$ 6,250	$ 6,250	15
16	V	27	EMP. BEN.-D. O'BRIEN				1,425	1,425	16
17	V								17
18	V	17	SALARY-P. O'BRIEN				36,250	36,250	18
19	V	27	EMP. BEN.-P. O'BRIEN				1,823	1,823	19
20	V								20
21	V	17	SALARY-C. STUMPF				49,111	49,111	21
22	V	27	EMP. BEN.-C. STUMPF				4,182	4,182	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 99,041	$ * 99,041	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$	$	15
16	V	6	REPAIRS AND MAINTENANCE						16
17	V	17	ADMINISTRATIVE SALARY				42,500	42,500	17
18	V	21	CLERICAL SALARY				27,475	27,475	18
19	V	27	GEN. ADMIN. - EMP. BEN.				13,257	13,257	19
20	V	30	DEPRECIATION-WAREHOUSE						20
21	V	33	REAL ESTATE TAXES						21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 83,232	$ * 83,232	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$ 35,586	WINDY CITY NURSING	100.00%	$ 35,586	$	15
16	V	3	HOUSEKEEPING	95,947	WINDY CITY NURSING	100.00%	95,947		16
17	V	5	MAINTENANCE	31,318	WINDY CITY NURSING	100.00%	31,318		17
18	V	10	NURSING	265,258	WINDY CITY NURSING	100.00%	265,258		18
19	V	12	SOCIAL SERVICES	42,736	WINDY CITY NURSING	100.00%	42,736		19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 470,845			$ 470,845	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DANIEL O'BRIEN	OWNER	Dir. Of Operation	20.00%	SEE ATTACHED	6	15.00%	Salary	$ 223,500	17-1	1
2	DANIEL O'BRIEN	OWNER	Dir. Of Operation	20.00%	SEE ATTACHED	6	15.00%	Alloc. Salary	6,250	17-7	2
3	PETER O'BRIEN	OWNER	Administrative	60.00%	SEE ATTACHED	6	10.00%	Alloc. Salary	36,250	17-7	3
4	CHARLES STUMPF	RELATIVE	Administrative		SEE ATTACHED	17	37.78%	Alloc. Salary	49,111	17-7	4
5	JAMES WEST	RELATIVE	Clerical		SEE ATTACHED	6.9	17.25%	Alloc. Salary	9,509	21-7	5
6	KATHLEEN STUMPF	RELATIVE	Administrative		SEE ATTACHED	5	11.11%				6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 324,620		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	236,364	5	$ 7,328	$	40,864	$ 1,267	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	236,364	5	31,369		40,864	5,423	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	236,364	5	30,669		40,864	5,302	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	236,364	5	29,662		40,864	5,128	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	236,364	5	480,229	393,151	40,864	83,025	5
6	24	SEMINARS	PATIENT DAYS	236,364	5	473		40,864	82	6
7	25	AUTO EXPENSE	PATIENT DAYS	236,364	5	13,206		40,864	2,283	7
8	26	PROPERTY INSURANCE	PATIENT DAYS	236,364	5	17,140		40,864	2,963	8
9	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	236,364	5	80,619		40,864	13,938	9
10	30	DEPRECIATION	PATIENT DAYS	236,364	5	27,053		40,864	4,677	10
11	32	INTEREST	PATIENT DAYS	236,364	5	82,230		40,864	14,216	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	236,364	5	13,113		40,864	2,267	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 813,091	$ 393,151		$ 140,571	25

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	25,000	25,000	6	6,250	1
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED	24	5	5,698		6	1,425	2
3										3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	45	5	271,875	271,875	6	36,250	4
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	45	5	13,673		6	1,823	5
6										6
7	17	SALARY-C. STUMPF	AVG. HOURS WORKED	45	5	130,000	130,000	17	49,111	7
8	27	EMP. BEN.-C. STUMPF	AVG. HOURS WORKED	45	5	11,070		17	4,182	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 457,316	$ 426,875		$ 99,041	25

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION		1	2,669				1
2	6	REPAIRS AND MAINTENANCE	DIRECT ALLOCATION		1	20				2
3	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	311,812	311,812		42,500	3
4	21	CLERICAL SALARY	DIRECT ALLOCATION		2	89,754	89,754		27,475	4
5	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	50,832			13,257	5
6	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION		1	1,082				6
7	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	1,810				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 457,979	$ 401,566		$ 83,232	25

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Windy City Nursing
Street Address: 1541 N. Wells
City / State / Zip Code: Chicago, IL 60601
Phone Number: (312) 787-9400
Fax Number: (312) 987-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	DIRECT ALLOC.			$	$		$ 35,586	1
2	3	HOUSEKEEPING	DIRECT ALLOC.						95,947	2
3	5	MAINTENANCE	DIRECT ALLOC.						31,318	3
4	10	NURSING	DIRECT ALLOC.						265,258	4
5	12	SOCIAL SERVICES	DIRECT ALLOC.						42,736	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 470,845	25

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	INSURANCE FINANCING		X								2,274	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 2,274	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										14,216	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 14,216	14
15	TOTALS (line 9+line14)						$	$			$ 16,490	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC-MADO MGMT	X					$	$			$ 14,216	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 14,216	21

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	71,708	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	75,174	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,466	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	76,552	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	12,934	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	92,952	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	71,086	8
	1997	67,890	9
	1998	67,751	10
	1999	68,292	11
	2000	72,907	12

RE TAX ACCRUAL = 2000 TAX X 1.05

72907 X 1.05 = 76552

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MARGARET MANOR INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0011239

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-04-401-001	Long Term Care Property	$ 4,868.75	$ 4,868.75
2.	17-04-402-004	Long Term Care Property	$ 1,451.45	$ 1,451.45
3.	17-04-401-005	Long Term Care Property	$ 1,494.28	$ 1,494.28
4.	17-04-401-006	Long Term Care Property	$ 2,760.07	$ 2,760.07
5.	17-04-401-007	Long Term Care Property	$ 1,642.80	$ 1,642.80
6.	17-04-401-008	Long Term Care Property	$ 1,765.77	$ 1,765.77
7.	17-04-401-009	Long Term Care Property	$ 1,905.75	$ 1,905.75
8.	17-04-401-010	Long Term Care Property	$ 6,140.80	$ 6,140.84
9.	17-04-409-009	Long Term Care Property	$ 50,876.59	$ 50,876.59
10.	17-04-204-012	Allocated - Related Party	$ 19,284.33	$ 2,267.11
		TOTALS	$ 92,190.59	$ 75,173.41

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,250 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	26,250	1962	$ 2,000	1
2					2
3	TOTALS	26,250		$ 2,000	3

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1962	$ 17,867	$	35	$	$	$ 17,867	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1975	9,723		20	-		9,723	9
10	Various			1976	6,706		20	-		6,706	10
11	Various			1977	46,090		20	-		46,090	11
12	Various			1978	21,593		20	-		21,593	12
13	Various			1979	23,565		20	-		23,565	13
14	Various			1982	4,014		20	-		3,981	14
15	Various			1983	5,200		20	-		5,200	15
16	Various			1984	4,952		20	148	148	3,913	16
17	Various			1985	9,766		20	308	308	8,474	17
18	Various			1986	36,773		20	2,248	2,248	30,774	18
19	Various			1987	7,315		20	383	383	5,554	19
20	Various			1988	6,455		20	430	430	5,805	20
21	Various			1989	2,400		20	160	160	2,000	21
22	Various			1990	7,500		20	375	375	2,865	22
23	Various			1991	19,058		20	953	953	10,482	23
24	Various			1992	103,932		20	5,197	5,197	46,773	24
25	Various			1993	65,481		20	3,274	3,274	27,018	25
26	Various			1994	115,474		20	5,774	5,774	43,301	26
27	Various			1995	17,694		20	885	885	5,751	27
28	Various			1996	90,906		20	4,546	4,546	24,602	28
29	Various			1997	91,102		20	4,555	4,555	20,757	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		53,240	1,832		1,882	50	12,350	68
69	Financial Statement Depreciation			34,991			(34,991)		69
70	TOTAL (lines 4 thru 69)		$ 766,806	$ 36,823		$ 31,118	$ (5,705)	$ 385,144	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 766,806	$ 36,823		$ 31,118	$ (5,705)	$ 385,144	1
2	7 STEEL DOORS/1 WOOD	1998	845		20	42	42	161	2
3	INSTALL PATIO/3 CATC	1998	6,893		20	345	345	1,179	3
4	ROOF IMPROVEMENTS	1998	35,344		20	1,767	1,767	5,890	4
5	GATE & GATE OPENER	1998	6,100		20	305	305	940	5
6	9 WINDOWS	1998	2,245		20	112	112	345	6
7	TUCKPOINTING	1998	8,100		20	405	405	1,485	7
8	PATIO	1998	1,503		20	75	75	256	8
9	FENCING & GATE	1998	3,250		20	163	163	503	9
10	J & L DOORS	1998	1,960		20	98	98	392	10
11	KELCO-GENERATOR REP	1998	2,470		20	124	124	496	11
12	F&D-REPAIR,FIRE ESC.	1998	1,200		20	60	60	195	12
13	J&L-DOORS	1998	1,035		20	52	52	191	13
14	J&L-DOORS	1998	3,140		20	157	157	484	14
15	2 TON AC UNIT	1999	2,895		20	145	145	350	15
16	2 WINDOWS	1999	499		20	25	25	75	16
17	4 METAL DOORS	1999	2,794		20	140	140	338	17
18	DOOR CLOSERS	1999	1,151		20	58	58	131	18
19	DOOR CLOSERS	1999	1,640		20	82	82	185	19
20	BOILER REPAIR	1999	1,743		20	87	87	247	20
21	LANDSCAPING	1999	1,349		20	67	67	184	21
22	LANDSCAPING	1999	1,000		20	50	50	138	22
23	LANDSCAPING	1999	1,040		20	52	52	143	23
24	REPAIR-COURT YARD SE	1999	1,485		20	74	74	160	24
25	REPAIR-COURT YARD SE	1999	685		20	34	34	74	25
26	REPAIR FENCE/INST GA	1999	1,800		20	90	90	188	26
27	PAINTING & DECORATIN	1999	588		20	29	29	60	27
28	ROOF REPAIR	1999	3,400		20	170	170	354	28
29	POWER BOOST WORK	2000	16,489		20	824	824	1,236	29
30	WEATHERIZED DOORS	2000	500		20	25	25	50	30
31	BLINDS	2000	3,299		20	165	165	316	31
32	FLOOR COVERING	2000	3,162		20	158	158	250	32
33	DOOR FRAMING	2000	1,326		20	66	66	88	33
34	TOTAL (lines 1 thru 33)		$ 887,736	$ 36,823		$ 37,164	$ 341	$ 402,228	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 887,736	$ 36,823		$ 37,164	$ 341	$ 402,228	1
2	ROOF REPAIR	2000	4,400		20	220	220	293	2
3	PIPING	2000	1,985		20	99	99	132	3
4	CARPETS	2000	1,664		20	83	83	111	4
5	INSTALL TOILETS	2000	558		20	28	28	35	5
6	CEILING REPAIRS	2000	1,181		20	59	59	74	6
7	FAUCETS & BASINS	2000	538		20	27	27	32	7
8	REPAIR ELEVATOR DOOR	2000	749		20	37	37	43	8
9	PUMP	2001	1,822		20	91	91	91	9
10	VERTICAL BLINDS	2001	2,383		20	119	119	119	10
11	METAL DOOR	2001	1,453		20	73	73	73	11
12	RADIATORS INSTALLED	2001	17,863		20	893	893	893	12
13	1600 AMP ELECTRICAL	2001	32,565		20	1,628	1,628	1,628	13
14	CIRCUIT BREAKERS	2001	42,715		20	2,136	2,136	2,136	14
15	AIR CONDITIONING	2001	3,506		20	175	175	175	15
16	AIR CONDITIONING	2001	14,843		20	742	742	742	16
17	AIR CONDITIONING	2001	18,271		20	914	914	914	17
18	ELEVATOR DOOR	2001	2,820		20	141	141	141	18
19	GATE	2001	4,870		20	244	244	244	19
20	DOORS	2001	2,475		20	124	124	124	20
21	WATER LINES	2001	4,250		20	213	213	213	21
22	CURTAIN RODS	2001	2,756		20	138	138	138	22
23	PIPE REPAIRS	2001	535		20	27	27	27	23
24	SINK AND GREASE TRAP	2001	780		20	39	39	39	24
25	PLATE CAGES	2001	650		20	33	33	33	25
26	PUMP REPAIRS	2001	620		20	31	31	31	26
27	RADIATOR	2001	4,510		20	226	226	226	27
28	CONCRETE POSTS	2001	625		20	31	31	31	28
29	GATE OPERATOR AND KEYPAD	2001	1,750		20	88	88	88	29
30	BATHROOM REPAIRS	2001	2,630		20	132	132	132	30
31	ELEVATOR REPAIRS	2001	751		20	38	38	38	31
32	BATHROOM REPAIRS	2001	7,190		20	360	360	360	32
33	ELEVATOR REPAIRS	2001	1,543		20	77	77	77	33
34	TOTAL (lines 1 thru 33)		$ 1,072,987	$ 36,823		$ 46,426	$ 9,603	$ 411,657	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,072,987	$ 36,823		$ 46,426	$ 9,603	$ 411,657	1
2	CEILING TILES	2001	532		20	27	27	27	2
3	SINK REPAIRS	2001	1,520		20	76	76	76	3
4	CONCRETE POSTS	2001	1,275		20	64	64	64	4
5	GLASS PANES	2001	530		20	27	27	27	5
6	PUMP REPAIRS	2001	2,123		20	106	106	106	6
7	ELEVATOR REPAIRS	2001	878		20	44	44	44	7
8	DOOR CLOSERS	2001	1,019		20	51	51	51	8
9	BOILER REPAIR	2001	940		20	47	47	47	9
10	WATER LINES	2001	2,145		20	107	107	107	10
11	FAUCETS	2001	606		20	30	30	30	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,084,555	$ 36,823		$ 47,004	$ 10,181	$ 412,235	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1988		$ 35,835	$ 1,303	35	$ 1,024	$ (279)	$ 6,143	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED - MADO MANAGEMENT			1993	13,649	363	20	682	319	5,749	9
10	ALLOCATED - MADO MANAGEMENT			1995	831	166	20	42	(124)	271	10
11	ALLOCATED - MADO MANAGEMENT			2000	2,041	-	20	102	102	155	11
12	ALLOCATED - MADO MANAGEMENT			2001	884	-	20	32	(32)	32	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 53,240	$ 1,832		$ 1,882	$ (14)	$ 12,350	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 86,675	$ 4,463	$ 7,713	$ 3,250	10	$ 40,003	71
72	Current Year Purchases	11,424	8,351	1,110	(7,241)	10	1,110	72
73	Fully Depreciated Assets	165,689				10	165,689	73
74								74
75	TOTALS	$ 263,788	$ 12,814	$ 8,823	$ (3,991)		$ 206,802	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		86 OLDS	1990	$ 5,000	$	$	$	5	$ 5,000	76
77										77
78										78
79										79
80	TOTALS			$ 5,000	$	$	$		$ 5,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,355,343	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 49,637	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 55,827	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,190	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 624,037	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 7,210 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 49	$ 49	1
2	Cash-Patient Deposits	32,123	32,123	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	413,518	413,518	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,145	28,145	6
7	Other Prepaid Expenses	1,245	1,245	7
8	Accounts Receivable (owners or related parties)	5,876,730	7,701,627	8
9	Other(specify): See supplemental schedule	1,938	1,938	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,353,748	$ 8,178,645	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		109,834	13
14	Buildings, at Historical Cost		17,867	14
15	Leasehold Improvements, at Historical Cost	952,520	952,520	15
16	Equipment, at Historical Cost	246,010	246,010	16
17	Accumulated Depreciation (book methods)	(571,212)	(589,079)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	7,728	7,728	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 635,046	$ 744,880	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,988,794	$ 8,923,525	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 770,254	$ 770,254	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,205	1,205	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,892	24,892	30
31	Accrued Taxes Payable (excluding real estate taxes)	53	53	31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,552	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,960	7,960	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	1,773,933	1,821,205	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,578,297	$ 2,702,121	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,578,297	$ 2,702,121	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,410,497	$ 6,221,404	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,988,794	$ 8,923,525	48

*(See instructions.)

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,705,737	1
2	Restatements (describe):		2
3	INCOME RESTATEMENT	(51,880)	3
4	EXPENSE RESTATEMENT	(4,250)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,649,607	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	760,890	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 760,890	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,410,497	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,843,217	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,843,217	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See supplemental schedule	4,355	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,355	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,847,572	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	898,993	31
32	Health Care	733,515	32
33	General Administration	1,014,992	33
	B. Capital Expense		
34	Ownership	354,444	34
	C. Ancillary Expense		
35	Special Cost Centers	10,825	35
36	Provider Participation Fee	73,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,086,682	40
41	**Income before Income Taxes (line 30 minus line 40)****	760,890	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 760,890	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	637	657	12,060	18.36	3
4	Licensed Practical Nurses	1,302	1,343	19,253	14.34	4
5	Nurse Aides & Orderlies	30,818	33,577	224,674	6.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,947	9,636	66,685	6.92	10
11	Social Service Workers	8,083	8,809	74,704	8.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,037	10,975	68,862	6.27	15
16	Dishwashers	3,176	3,531	23,583	6.68	16
17	Maintenance Workers	3,395	3,483	21,826	6.27	17
18	Housekeepers	8,123	8,614	58,076	6.74	18
19	Laundry	1,993	2,113	12,156	5.75	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	312	312	223,500	716.35	22
23	Office Manager					23
24	Clerical	3,137	3,431	22,810	6.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	79,960	86,481	$ 828,189 *	$ 9.58	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	135	$ 3,381	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	3	108	10a-03	40
41	Occupational Therapy Consultant	76	3,563	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	4,566	11-03	44
45	Social Service Consultant	12	960	12-03	45
46	Other(specify)				46
47	OUTSIDE LABOR - SOCIAL SERV	3,419	42,736	12-03	47
48	OUTSIDE LABOR - DIETARY	2,849	35,586	01-03	48
49	TOTAL (lines 35 - 48)	6,590	$ 90,900		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8,905	$ 191,248	10-03	50
51	Licensed Practical Nurses	4,082	74,010	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	12,987	$ 265,258		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DANIEL O'BRIEN	Administrative	20%	$ 223,500
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 223,500

B. Administrative - Other

Description	Amount
MADO MGMT - MANAGEMENT FEES	$ 452,500
FELIX MORALES	2,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 454,500

C. Professional Services

Vendor/Payee	Type	Amount
WOLF & COMPANY	ACCOUNTANTS	$ 3,644
LASALLE APPRAISAL GRP	REAL ESTATE TAX APPR	2,750
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	1,260
FROST, RUTTENBERG & ROTH	ACCOUNTANTS	10,415
HEALTH DATA SYSTEMS	DATA PROCESSING	4,392
ROCK, FUSCO & GARVEY	LEGAL	1,471
HYNES	LEGAL	10,184
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 34,116

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 17,979
Unemployment Compensation Insurance	7,069
FICA Taxes	54,378
Employee Health Insurance	
Employee Meals	28,496
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	8,876
TOTAL (agree to Schedule V, line 22, col.8)	$ 116,798

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,183
Health Care Worker Background Check	22
(Indicate # of checks performed 2)	
LICENSES AND FEES	2,540
ADVERTISING AND PROMO	2,839
ALLOC-MADO MGMT	5,128
ALLOC-BLDG CO	120
Less: Public Relations Expense	
Non-allowable advertising	(2,839)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,193

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,036
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,036

**See instructions.

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MARGARET MANOR INC. # 0011239 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES 10yrs
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 73,913
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 28,496 Has any meal income been offset against related costs? NO Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%In 1
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees